

# AMA, Anthem try new tack: Working together to improve health care

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Two major health care organizations announced today they are working together to figure out mutually agreeable ways to improve patients' access to health care that is timely, high quality and affordable. This year, the AMA and Anthem—whose health plans cover more than 40 million people—will pursue collaboration in four key areas to:

- Enhance consumer and patient health care literacy.
- Develop and implement value-based payment models for primary and specialty care physicians.
- Improve access to timely, actionable data to enhance patient care.
- Streamline or eliminate low-value prior-authorization requirements.

“Physicians caring for patients across the country have many ideas about how we can reduce health care costs and administrative burdens while improving clinical outcomes, and we need the collaboration of Anthem and all health plans to implement those strategies,” AMA Board Chair Gerald E. Harmon, MD, said. “The AMA looks forward to finding common ground on ways to improve the delivery of affordable, high-quality, patient-centered care.”

Anthem Chief Clinical Officer Craig Samitt, MD, said collaboration between physicians and payers “is critical in order to evolve and advance our health care system to one that is simpler, more accessible and more affordable for our consumers.”

This collaboration may signal a new type of dialogue and engagement between insurers and physicians. In a letter to the AMA last week, Anthem's Dr. Samitt announced the insurer's decision to not proceed with a planned cut in payments for significant, separately identifiable evaluation-and-management (E/M) services billed with a Current Procedural Terminology modifier 25 that are provided on the same day as a procedure or a wellness exam. This policy was set to take effect March 1, but Anthem reconsidered following strong advocacy efforts by the AMA and other physician

organizations.

Of note, Dr. Samitt's letter also expressed a commitment to continuing work with the AMA, state medical associations and national medical specialty societies to address physician concerns with other policies and guidelines. Organized medicine has raised concerns regarding Anthem's policies on the retrospective denial of payment for emergency department visits, restrictions on advanced imaging in hospital outpatient facilities and the denial of payment for monitored anesthesia care or general anesthesia for cataract surgery.

In discussions about the modifier 25 payment reduction and other policies of concern to physicians, it became clear to leaders at the two organizations that they could exert a major positive impact on the direction of health care through collaborative efforts.

For example, both payers and physicians recognize the power of data analytics to identify and address care gaps to improve patient outcomes and cut costs. Improved exchange of data between payers, physicians and patients covering areas such as insurance benefits, quality and health care costs could help improve the value of care for patients.

On prior authorization, the AMA and Anthem's collaboration can build on efforts already underway. Anthem is a member of two organizations—America's Health Insurance Plans and the Blue Cross Blue Shield Association—that joined the AMA and other major health care stakeholders last month in releasing a consensus statement that targets the administrative burdens of prior-authorization (PA) and utilization-management requirements.

A December 2016 AMA survey of 1,000 practicing physicians measured the burden created by PA requests and the impact on timely patient care. Practices reported completing an average of 37 PA requests per physician per week, which consume 16.4 hours of physician and staff time.

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